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ABSTRACT

The 11 publications reviewed in this annotated bibliography discuss such aspects of clinical supervision as inservice application techniques in the clinical supervision of teachers, clinical supervision rationale, the microsupervisory experience's humanistic and clinical format, what principals should look for in classroom observations to help teachers to grow, facilitating teacher self-improvement, and clinical supervision a decade after Goldhammer. Additional publications covered focus on the inservice training of administrators in the supervision of content area reading teachers, competencies in clinical supervision, clinical supervision research, the advantages of supportive teacher supervision over clinical supervision, and the state of the art of clinical supervision. (JBM)

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THE BEST OF ERIC

ON EDUCATIONAL MANAGEMENT

Number 72, January 1984

The Best of ERIC presents annotations of ERIC literature on important topics in educational management.

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Clinical Supervision

1 **Acheson, Keith A., and Gall, Meredith Damien.** *Techniques in the Clinical Supervision of Teachers: Preservice and Inservice Applications*. New York: Longman, Inc., 1980. 198 pages. ED 199 913.

This book differs from other texts written on clinical supervision over the past decade in that, whereas they have generally emphasized theory and research, the content of this book is entirely practical in intent. As Acheson and Gall state, "We emphasize the techniques of clinical supervision, the 'nuts and bolts' of how to work with teachers to help them improve their classroom teaching."

In textbook format, the book seeks to help the supervisor (1) understand the three phases of clinical supervision—planning conference, classroom observation, and feedback conference; (2) gain knowledge and skill in holding conferences with teachers and in observing their classroom teaching; (3) understand issues and problems in doing clinical supervision; (4) realize role differences of the supervisor as facilitator, evaluator, counselor, and curriculum advisor; and (5) acquire a positive attitude toward clinical supervision as a method of promoting teacher growth.

To achieve these objectives, the book is divided into four units, the first of which provides the necessary background for understanding the techniques of clinical supervision. The next two units describe specific techniques for conducting clinical conferences and collecting observation data. The final unit presents case studies and answers questions frequently asked about clinical supervision.

Although the book's content can be taught in several formats, the authors recommend taking up the observation techniques first. This gives the participants in clinical supervision the opportunity to practice in a live setting and, whenever possible, to elicit experiences and data from other members of the class. The book's value, however, is not confined to the classroom. School administrators responsible for supervising and evaluating teachers may consult it as a handbook. It can also be used by teachers who are interested in self-analysis or peer observation.

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2 **Cogan, Morris L.** "Rationale for Clinical Supervision." *Journal of Research and Development in Education*, 9,2 (Winter 1976), pp. 3-19. EJ 140 590.

So many terms have been applied to clinical supervision that there is much confusion about who is a supervisor. Cogan seeks to avoid some of this confusion by differentiating "between the administration of programs of supervision and the act of supervising."

Cogan defines the *administration of supervision* as "the performance of executive duties related to the management and conduct of programs for the improvement of instruction." These duties include responsibilities that support the work of the supervisors: implementation, funding, staffing, development of policy, improvement of supervisory operations, and formative and summative evaluation of supervisory programs.

General supervision, according to Cogan, is "concerned with the selection and preparation of curriculums and materials of instruction, the development of inservice courses and workshops, the evaluation of instructional materials, and the coordination of auxiliary services for instruction."

In 1973, Cogan defined clinical supervision as "the rationale and practice designed to improve the teacher's classroom performance. It takes its principal data from the events of the classroom."

According to Cogan, the rationale for clinical supervision derives from the urgent needs of teachers. The first of these needs comes from the inadequacies in the preservice education of teachers. The second is a consequence of the underdeveloped practices of supervision in schools; coupled with this is the need for a system of supervision that will help teachers adapt to the constant changes in education. Finally, clinical supervision meets the need for "a psychological-sociological frame of reference" for the "procedures, attitudes, goals, relationships, and ethics" that govern the supervisory process.

3 **Diamond, Stanley.** "Micro-Supervisory Experience, Humanistic and Clinical Format." *NASSP Bulletin*, 64, 434 (March 1980), pp. 25-9. EJ 217 703.

Unlike traditional clinical supervision, which focuses on the teacher's overall relationships with students or a class's behavior or control, the Micro-Supervisory Experience is a "self-contained, brief supervisory sequence." A Micro-Supervisory Experience is, according to Diamond, only one part of the potential overall supervisory function. Yet, by being a humanistic and clinical format that can be effective even in situations where a minimal amount of supervision is possible, the MSE "enhances the teacher's performance and self-image immediately and makes a substantive contribution to the improvement of instruction."

The design of the MSE enables the supervisor to develop a supportive and nonevaluative relationship with a teacher. The model also takes into account the normal limitations of available supervisory time. Diamond believes that teachers desire and deserve an opportunity to plan with and get needed feedback from resource personnel. The MSE meets these various needs.

The MSE has six basic parts: interactions between supervisor and teacher focus on one goal or one closely tied set of teacher-perceived goals; the supervisor enters a partnership with the teacher

to provide feedback, support, and resources; the format and focus of the MSE are designed by the teacher and supervisor to address a specific task or problem; there is a prearranged limit of several conferences during a well-defined period; supervision during the MSE is limited to issues relating to the project itself; the MSE concludes with a conference that is designed for evaluative and generalizing purposes and that may suggest future goals.

Diamond maintains that the more individual and humanistic approach of the Micro-Supervisory Experience, which regards the teacher as a person who has motivation and a personal investment in growing professionally, is absolutely essential. Thus, an openness on the part of the supervisor to learning (as well as teaching) during the MSE is equally essential.

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4 **Dunkleberger, Gary E.** "Helping Teachers to Grow: Classroom Observations—What Should Principals Look for?" *NASSP Bulletin*, 66, 458 (December 1982), pp. 9-15. EJ 274 276.

"Teacher observation," says the author of this article, "should never be viewed only in the narrow perspective as a tool in the hire-fire process." Dunkleberger stresses the advantages to student motivation and overall educational effectiveness when teacher skepticism toward clinical supervision is eliminated. He points out that, unless this skepticism is first removed, the teacher often rationalizes suggestions or criticism and, thus, circumvents the entire philosophy of helping teachers grow.

Dunkleberger describes in detail the processes for clarifying and identifying the criteria necessary for achieving the optimum results from the observation process. These criteria fall into the four major categories of Planning, Teaching Skills, Instructional Skills, and Classroom Management. An examination of these criteria forms the basis of an effective framework for teacher observation. According to Dunkleberger, elements within this framework include evidence of planning, materials preparation, instructional aids, evaluation/feedback of student progress, student motivation, quality and variety of activities, communication, social management, interpersonal regard, and discipline.

"Evaluating teachers," Dunkleberger states, "serves a twofold purpose. While it serves to quantify teaching performance for the purposes of promotion, dismissal, or nonrenewal, more importantly it assists competent teachers in recognizing both their strengths and their weaknesses so that the former may be capitalized upon and the latter properly addressed." Dunkleberger maintains that the entire process of clinical supervision should be embraced by the teacher and viewed as an essential tool for maximum growth.

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5 **Krajewski, Robert J.** "Clinical Supervision: To Facilitate Teacher Self-Improvement." *Journal of Research and Development in Education*, 9, 2 (Winter 1976), pp. 58-66. EJ 140 595.

Whereas in theory it is commonly accepted that research and development should work hand in hand toward a common objective, in reality the relationship has a tendency to become "lost in the shuffle." In this article Krajewski pursues the idea of clinical supervision as enhancing teacher self-improvement and follows this idea through both research and development phases.

Krajewski points out that the biggest problem with implementing clinical supervision is that in practice it is not accepted. He contends that most supervisors today lack the necessary skills to adequately analyze teaching behavior, for two main reasons. First, university supervisor training programs are inadequate. And second, supervisors receive far too little on-the-job training in clinical supervision skills. Research in clinical supervision is, likewise, also lacking.

Krajewski then offers a developed model, thoroughly tested and formulated in accord with relevant research findings. To be utilized, the model requires the services of a clinical supervisor who will be in a face-to-face relationship with a teacher. The model suggests that the teacher list objectives and then analyze them with any or all ratings and analyses. But, Krajewski stresses, "the teacher self-improvement model does not propose that the supervisor abdicate his responsibilities of working with the teacher to help establish objectives of self-improvement procedures." Instead, the goal is that the supervisor and teachers, individually and in groups, work in setting up model procedures for the improvement of instruction.

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6 **Krajewski, Robert J., and Anderson, Robert H.** "Goldhammer's Clinical Supervison a Decade Later." *Educational Leadership*, 37, 5 (February 1980), pp. 420-23. EJ 216 064.

The authors of this informative article suggest that "the ideas and practices associated with clinical supervision are insufficiently known and appreciated." The purpose of their paper is to evaluate Robert Goldhammer's seminal work in the field of clinical supervision. During the more than a decade that has passed since Goldhammer's death and the subsequent publication of his main ideas (by his principal mentor Morris Cogan), the research, development, and publications in the area of clinical supervision have been profuse.

After updating the original Goldhammer volume, Krajewski and Anderson wondered "how Goldhammer himself would have chosen to do so," and they "invented the idea of a three-way interview" to reveal "at least one set of predictions or estimates of Goldhammer's viewpoint were he still alive."

The bulk of this article, then, is a partially imaginary discussion among Goldhammer, Krajewski, and Anderson. Through the questions and answers, Krajewski and Anderson give their views regarding various key aspects of clinical supervision. Among their opinions: supervisors want less emphasis on the methods and more on the concept of clinical supervision; if clinical supervision had been called by a different name, it would have been accepted less reluctantly by teachers and would have grown more rapidly; and the implementation of clinical supervision ought to follow some plan that is embraced psychologically by both the supervisor and the teacher.

The authors discuss Goldhammer's original concept of the goals of clinical supervision, the history of the various difficulties of its implementation, and Goldhammer's view that, on the whole, clinical supervision should be systematic. Perhaps the most important point made in the entire article is offered by the imaginary Goldhammer: "the aims of clinical supervision will be realized when, largely by virtue of its own existence, everyone inside the school will know why they are there, will want to be there, and will feel a strong and beautiful awareness of their individual identity and a community of spirit and enterprise with those around them."

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7 **Laine, Chester H.** "Inservice Training of Administrators in the Supervision of Content Area Reading Teachers." Paper presented at the Annual Meeting of the American Reading Forum, Sarasota, FL, December 10-12, 1981. 9p. ED 211 965.

Laine examines eight premises for the training of administrators in the clinical supervision of content area reading teachers. The eight premises form the model of the *Instructional Supervision Process*, developed by Boyan and Copeland (1978), which can be adapted for use by project administrators.

First, any problems encountered in the content classroom can

be resolved if the teacher changes his or her behavior in positive ways. Second, recognition of needed change in behavior must come from within, not be imposed from without. Third, content teachers are often unaware of many teaching and learning behaviors that occur in their classrooms. They are seldom able to monitor their own behavior.

Fourth, increased awareness of behaviors in the classroom can help content teachers recognize needed changes. Through systematic methods of clinical supervision, teachers can receive essential feedback. Fifth, existing behaviors can be revealed to the teacher through systematic observation. When given specific information, teachers can change their behavior and improve instruction.

Sixth, because it is difficult for the content teacher to apply systematic observation techniques while teaching, a trained observer is needed. While students, peers, videotapes, and self-analyses are potentially useful to a teacher, the trained observer makes the best source for information concerning classroom behavior.

Seventh, the observer must present the observation results to the content teacher in a way that will allow the teacher to accept them as valid, to internalize them, and to use them to identify needed instructional changes.

And eighth, the teacher will accept and internalize observation results best when there is a "no threat" relationship between the teacher and the supervisor. Supervision to improve instruction must be divorced from administration and evaluation.

Laine concludes that "the role of the supervisor is not that of an evaluator." Clinical supervision should become "something that is done together" by the content teacher and the supervisor who share "the expert role."

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8 **McCleary, Lloyd E.** "Competencies in Clinical Supervision." *Journal of Research and Development in Education*, 9, 2 (Winter 1976), pp. 30-5. EJ 140 592.

"No program for the training of supervisors, system for assessing the performance of supervisors, or strategy for the improvement of supervision can be undertaken without the specification of what supervisors must be able to do when they engage in the act of supervising," explains McCleary. The purpose of this article is to identify what is known, or not known, about supervisor competencies.

McCleary maintains that sources of competencies lie in two directions: one is in the analysis of practice and the other is in the knowledge of the field (particularly the authoritative literature). Cogan and Goldhammer, the authors of two major texts, did not attempt to provide "a documented empirical base" for their assertions. According to McCleary, Abrell's definition of the process of clinical supervision leads to a much clearer understanding of competencies: establishing an open, trusting, and collegial relationship; identifying needs, aspirations, talents, and goals of both persons and institutions in which the trusteeship is to take place; planning what is to be done, how it is to take place, and when it is to occur; observing performance by "taking the role" of the performer; and analyzing performance, holding conferences, and sharing appraisal feedback.

McCleary concludes by countering some of the criticisms that have centered upon the identification of competencies. McCleary stresses that "competency statements need not be highly specific behavioral objectives," that competencies are "usually not identified merely through job analysis techniques," that the "relevance of training needs to be assessed constantly," and that "training must go well beyond mere job training for existing positions."

9 **Reavis, Charles A.** "Research in Review/Clinical Supervision: A Review of the Research." *Educational Leadership*, 35, 7 (April 1978), pp. 580-4. EJ 179 220.

Before beginning his highly informative review of research on clinical supervision, Reavis lucidly summarizes Goldhammer's five-step process. Those steps are as follows: *preobservation conference* (the supervisor is oriented to the class), *observation* (the supervisor observes the lesson), *analysis and strategy* (the supervisor considers any teaching patterns, either favorably or unfavorably), *postobservation conference* (the supervisor implements his or her own strategy), and *postconference analysis* (the supervisor anaylzes his or her own performance and makes plans for working with the teacher).

Some of the research has been flawed by faulty procedures, warns Reavis. Nevertheless, with three studies in basic agreement, at least one finding warrants reasonable confidence: "teachers favor the clinical supervision approach." No study has found that teachers favor traditional methods of supervision. Further, Reavis deduces that, "on balance, considering the studies available, one can safely say that no study has found traditional supervision effective in changing teacher behavior when compared to clinical supervision."

One researcher, N. D. Skarak, sought to determine whether clinical supervision used in conjunction with an "immediate secondary reinforcement of a preselected teacher behavior" would be more effective than clinical supervision alone. Immediate reinforcement, according to Reavis, is well recognized as "a very powerful training tool." The fact that Skarak found no difference between the two underscores the effectiveness of clinical supervision in changing teacher behavior.

10 **Reilkoff, Theresa.** "Advantages of Supportive Supervision over Clinical Supervision of Teachers." *NASSP Bulletin*, 65, 448 (November 1981), pp. 28-34. EJ 252 242.

Reilkoff maintains that clinical supervision—the supervisory model of current and widespread practice—should be eliminated. Clinical supervision, according to the author, is formalistic, time consuming, and ultimately incompatible with the evaluatory process. It should be replaced by *supportive supervision*.

After examining the background and practice of clinical supervision, Reilkoff describes supportive supervision as a system in which supervisor and teacher collaborate to assess and maximize student performance. As opposed to clinical supervision, which focuses on teacher behavior, supportive supervision focuses on the student. The goal of supportive supervision is the improvement of student attitudes, behaviors, and learning outcomes. Unlike clinical supervision, supportive supervision does not lead to the teacher being evaluated or criticized.

The assumption of supportive supervision is that the supervisory model can be simple, practical, and inexpensively administered. And, since the system is centered around the student and not the teacher, the performance of the student is stressed. Teachers work with supervisors to diagnose problems, observe students, and structure improvement where necessary. Thus, supportive supervision provides support and guidance necessary for a teacher to improve student learning.

The supportive supervision model can be broken down into six major "action patterns." These patterns enable the supervisor to observe student attitudes, behaviors, and learning outcomes; confer with the teacher; listen to teachers' action suggestions and help to design alternative solutions; refer to human and nonhuman resources whenever necessary; aid in implementing these solutions; and evaluate the process.

These action patterns make up the "Gyre Implementation Model," which, according to Reilkoff, "is a collegial, student-oriented means of practicing the Six-Phase Supportive Supervisory Program. Its spiral-like schematic construction lets every participant be in touch with every other participant. The supportive supervisor (principal) coordinates the various gyres as well as functioning as a gyre member."

11 **Sullivan, Cheryl Granade.** *Clinical Supervision: A State of the Art Review*. Alexandria, Virginia: Association for Supervision and Curriculum Development, 1980. 55 pp. EJ 182 822.

Is clinical supervision a potentially valuable method for educational improvement? Or is it, perhaps, "nothing more than hollow claims"? If the former, says Sullivan, a summary of the characteristics of and experience with clinical supervision should exist. If the latter, "then the fallacies of the system need to be exposed." Although the final word on clinical supervision is not in and may not be for some time, Sullivan's presentation here concisely summarizes what is presently known about the history, process, and effectiveness of clinical supervision.

Sullivan describes clinical supervision as an eight-phase cycle of instructional improvement. First, the supervisor establishes the clinical relationship with the teacher by explaining the purpose and sequence of clinical supervision. In phases two and three, the planning of lessons and evaluation of the lessons take place. In phase four, the supervisor observes the teacher and records appropriate data. Following the observation, the teacher and supervisor "analyze the teaching-learning process," especially "critical incidents and pattern analysis."

Phases six and seven encompass the planning and conduct of a teacher-supervisor conference, wherein "the teacher begins to make decisions about his/her behavior and students' behaviors and learning." Phase eight is entered when the kinds of changes sought in the teacher's behavior are decided upon. Throughout, the emphasis is on improving instruction through direct feedback, without centering on rating forms or items that are exogenous to improving instruction.

Research on clinical supervision is, at present, "sparse," says Sullivan, "and that which does exist reflects a lack of rigor often associated with a new field of inquiry." Sullivan reviews this research, finds some evidence supporting the model and then outlines the needs for further research. Two final chapters discuss the strengths and weaknesses of clinical supervision and implications for the future of this supervisory technique.

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